Financial Reporting Guide

Prepaid Health Plan

Revised November 7, 2014 v2

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Introduction and general instructions

1.01 Introduction

The provisions and requirements of this Financial Reporting Guide (Guide) are effective February 1, 2012. The purpose of this Guide is to set forth quarterly and annual reporting requirements for BAYOU HEALTH Contractors (Contractors) contracted with Louisiana (LA) Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF) for prepaid care. The Guide instructions and reports are supplementary to any Department of Insurance (DOI) financial reporting requirements. This Guide does not replace any DHH electronic data submission requirements or quality/compliance-oriented reporting requirements from Contractors.

The primary objective of the Guide is to establish consistency and uniformity in reporting. All reports shall be submitted as outlined in the general and report-specific instructions. The financial reports submitted based on the Guide will be used to monitor the operations for participating Contractors and as a potential data source in capitation rate setting. Only revenues and expenses related to a direct contract between the State and the Contractor should be included in the reports, with the exception of parent organization financial statements and audit information required on an annual basis.

All terms and conditions of the Contract apply to this financial reporting guide. Current contractual requirements can be found at makingmedicaidbetter.com. This reporting guide may be revised as deemed necessary by DHH. Sanctions may be enforced for the untimely filing of the financial reports. Monthly reporting of the financial statements may also be enforced upon the discretion of DHH. This reporting guide is supplemental to any reporting provisions required by DHH, state and federal law, or Department of Insurance.

1.02 Reporting time frames

Amendments and/or updates to this Guide may be issued by the DHH as deemed necessary. The following table depicts reporting requirements and scheduling. Due dates are based on calendar days.

Schedule	Report name	Frequency	Due date[1]	Format
A	Income Statement	Quarterly	60 days after quarter end	Predetermined
B	Footnote Disclosures	Quarterly & annual	60 days after quarter end and 180 days after year end	Narrative
C	Total Profitability by Eligibility Category	Quarterly	(This schedule is a roll-up of D-L. Data is not entered on this schedule)	Predetermined
D-L	Region Profitability	Quarterly	60 days after quarter end	Predetermined
M	Medical Liability Summary	Quarterly	60 days after quarter end	Predetermined
N	Received But Unpaid Claims	Quarterly	60 days after quarter end	Predetermined
O	Hospitalization Services Lag	Quarterly	60 days after quarter end	Predetermined
P	Outpatient Facility Services Lag	Quarterly	60 days after quarter end	Predetermined
Q	Physician Services Lag	Quarterly	60 days after quarter end	Predetermined
R	Other Medical Services Lag	Quarterly	60 days after quarter end	Predetermined
S	Pharmaceutical Lag	Quarterly	60 days after quarter end	Predetermined
T	Utilization Report	Quarterly	60 days after quarter end	Predetermined
U	Pharmaceutical Statistics	Quarterly	60 days after quarter end	Predetermined
V	Sub-Capitated Expenses detail	Quarterly	60 days after quarter end	Predetermined
W	FQHC/Rural Health Clinic Payments	Quarterly	60 days after quarter end	Predetermined
X	Third party resource Payments	Quarterly	60 days after quarter end	Predetermined
Y	TPL subrogation	Quarterly	60 days after quarter end	Predetermined
Z	Fraud and Abuse	Quarterly	60 days after quarter end	Predetermined

Schedule	Report name	Frequency	Due date[1]	Format
AA	Parent Company Audited Financial Statements	Annual	180 days after year end	Embedded PDF
AB	MCO Agreed Upon Procedures	Annual	180 days after year end	Embedded PDF
AC	Annual Income Statement Reconciliation	Draft and final annual	90 and 180 days after year end	Predetermined
AD	Agreed Upon Procedures Adjustments	Draft and final annual	90 and 180 days after year end	Predetermined
AE	MLR Rebate Calculation	Quarterly and Annual	60 days after quarter end and 180 days after year end	Predetermined
AF	Supplemental working area	As needed	As needed	Narrative
Appendix A	Financial disclosure statement	Annual	90 and 180 days after year end, if adjustments are necessary	Predetermined
Appendix B	Medical Loss Ratio (MLR) guidelines	N/A	N/A	N/A

[1]If a due date falls on a weekend or State-recognized holiday, reports will be due the next business day.

1.03 General instructions

Generally accepted accounting principles (GAAP) are to be observed in the preparation of these reports. Specifically, all revenues and expenses must be reported using the accrual basis method of accounting.

Amounts reported to DHH under this Guide are to represent only **covered services** for recipients eligible for the BAYOU Health Program. Covered services are services that would be considered reimbursable under each Contractor's contract with DHH.

All quarterly and annual reports must be completed and submitted to DHH by the due dates outlined above. DHH may extend a report deadline if a request for an extension is communicated in writing and is received at least five business days prior to the report due date. Any request for extension must include the reason for delay and the date by which the report will be filed.

Most line and column descriptions within each report are self-explanatory and, therefore, constitute instructions. However, specific instructions are provided in instances when interpretation may vary. Any entry for which no specific instruction is provided should be made in accordance with sound accounting principles and in a manner consistent with related items for which instruction is provided.

Always utilize predefined categories or classifications before reporting an amount as "Other." For any material amount included as "Other", the Contractor is required to provide **a detailed explanation**. For this purpose, material is defined as comprising an amount greater than or equal to 5% of the total for each section. For example, if “Other Income” reported is less than 5% of Total Revenue, no disclosure is necessary. However, if “Other” miscellaneous medical expense is reported with a value that is equal to 5% or higher of Total Other Medical expenses, disclosure would be necessary. Such disclosure is to be documented on Schedule B – Footnotes, line item 3. Refer to the Schedule AF – supplemental working area if additional space is needed for disclosures.

Unanswered questions and blank lines or schedules will not be considered properly completed and may result in a resubmission request. Any resubmission must be clearly identified as such. If no answers or entries are to be made, write "None," not applicable (N/A) or "-0-" in the space provided.

Input areas for the spreadsheet are shaded in red. The Contractor should input amounts in whole dollars only. Amounts should be rounded up to or down to the nearest whole dollar. For example, $1.49 would be rounded down and input as $1; $1.50 would be rounded up and input as $2, the next whole number.

1.04 Format and delivery

The Contractor will submit these reports electronically, using Excel spreadsheets in the format and on the template specified in this Guide without alteration. A hard copy original of the attestation is required. Please submit the signed attestation page to:

Steve Annison
Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

Please submit the completed electronic copies of the reports and required supplemental materials, such as narrative support for “Other” categories that are considered material in nature, to:

- Steve Annison at DHH: Steve.Annison@la.gov
- Stewart Guerin at DOI: sguerin@ldi.la.gov

If a previously unaudited quarter is changed materially, that quarter’s report should be resubmitted with an explanation for the change to the address above.

1.05 Certification statement

The purpose of the certification statement is to attest that the information submitted in the reports is current, complete and accurate. The statement should include the Contractor name, period ended, preparer information and signatures. The certification statement must be signed by the Contractor’s CFO or CEO.

1.06 Financial statement check figures and instructions

In addition to the schedules that must be completed by the Contractor, the Guide includes a "Financial Statement Instruction and Check Figures Report" worksheet that evaluates the consistency of the values entered by the Contractor. The financial statement reporting template instructions and check figures tab lists the instructions for completing the spreadsheet, as well as check figures that identify any differences within specific schedules. The check figures must match prior to the submission of the quarterly and annual financial statements. If the audit check figures do not match, data should be corrected or an explanation should be provided in writing and submitted with the quarterly financial statement reporting package.

1.07 Maintenance of records

The Contractor must maintain and make available to DHH upon request the data used to complete any reports contained within this Guide.

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Quarterly report specifications

2.01 Schedule A: Income Statement

The Contractor shall report revenues and expenses using the full accrual method. The income statement, Schedule A, must agree to the total profitability by eligibility category report, Schedule C, for the quarterly reporting period.

Specification	Inclusion	Exclusion
Member months	A member month is equivalent to one member for whom the Contractor has received or accrued capitation-based revenue for the entire month.	Remove member months for recipients where a maternity delivery has occurred within the quarterly month end.
Maternity delivery payment count	Report the number of maternity payments received and/or accrued for from DHH.	
Capitation revenue	Revenue received and accrued on a prepaid basis for the provision of covered services.	
Maternity delivery payments	Revenue received and/or accrued for all supplemental maternity delivery payments.	
Investment income	All investment income earned during the period net of interest expense.	
ACA 1202 Revenue	Prospective capitation and proceeds or payments for final settlement of ACA 1202 payments for physician services.	
HIPF 2013	Health Insurer's Provider Fee paid in 2014 for 2013 revenue.	
HIPF 2014 (accrued)	Health Insurer's Provider Fee accrued in 2014 and payable in 2015. Pursuant to FASB 2011-06, this amount should be $0 and amounts should not be expensed until the year assessed and paid.	
Other income	Revenue from sources not identified in the other revenue categories. Describe amounts in the footnotes in Schedule B. Note: Material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.	

Medical expenses and recoveries – All medical expenses must be reported net of third party reimbursement and coordination of benefits (e.g., Medicare and other commercial insurance) and in correspondence to the identified categories of service in Schedule A. Expenses should be reported as paid and incurred for each line item to include IBNP estimates.

Specification	Inclusion	Exclusion
Medical expenses – hospitalization, outpatient, physician, other medical expenses and pharmaceuticals	All contracted fee-for-service and sub-capitation expenses as identified in the categories of service groupings. Descriptions are self-explanatory.	
Medical expenses – other and miscellaneous	Medical expenses that do not fall within the categories of services as defined in the reporting format. Note: Material other amounts (greater than 5% of the individual sections of expense) should be disclosed and fully explained in Schedule B.	
Reinsurance premiums	Reinsurance premium payments and stop loss payments should be separately reported as premium payments.	
Reinsurance recoveries	Reinsurance recoveries associated with the premiums paid in the line item above.	
Third party liability subrogation	Cost-sharing revenue, including third party sources received on a cash basis for subrogation recovery efforts that could not be directly associated with a claim.	Do not include coordination of benefit payments that are deducted from payments to providers in the normal course of claims processing.
Fraud and abuse recoveries	Payments to the Contractor as a result of DHH, Contractor or Provider sponsored recovery efforts.	
Other recoveries	Other recoveries of medical claims previously paid not included in a category above.	

Administrative expenses – Administrative expenses are divided into activities that improve health care quality and those that are other, general and operational, to perform necessary business functions. Use the following guidance for reporting activities that meet the criteria for improving health care quality.

Administration – Health care Quality Improvement expenses

Activity requirements

Activities conducted by the Contractor to improve quality must meet the following requirements. The activity must be designed to:

- Improve health quality.
- Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and producing verifiable results and achievements.
- Be directed toward individual enrollees, or incurred for the benefit of specified segments of enrollees, or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.
- Be grounded in evidence-based medicine, widely-accepted best clinical practice or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally-recognized health care quality organizations.
- Improve health outcomes, including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.

  Examples include the direct interaction of the Contractor (including those services delegated by subcontract for which the Contractor retains ultimate responsibility under the terms of the contract with DHH) with providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:
  - Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined in the RFP and contract.
  - Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence-based medicine.
  - Quality reporting and documentation of care in non-electronic format.
  - Health information technology to support these activities.
  - Accreditation fees directly related to quality of care activities.

  Prevent hospital readmissions through a comprehensive program for hospital discharge – Examples include:
  - Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital.
  - Patient-centered education and counseling.
  - Personalized post-discharge reinforcement and counseling by an appropriate health care professional.
  - Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.
  - Health information technology to support these activities.

  Improve patient safety, reduce medical errors and lower infection and mortality rates – Examples of activities primarily designed to improve patient safety, reduce medical errors and lower infection and mortality rates include:
  - The appropriate identification and use of best clinical practices to avoid harm.
  - Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.
  - Activities to lower the risk of facility-acquired infections.
  - Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions.
  - Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.

- Health information technology to support these activities.

Implement, promote, and increase wellness and health activities – Examples of activities primarily designed to implement, promote and increase wellness and health activities include:

- Wellness assessments.
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements.
- Coaching programs designed to educate individuals on clinically-effective methods for dealing with a specific chronic disease or condition.
- Public health education campaigns that are performed in conjunction with the LA DPH.
- Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs) that are not already reflected in payments or claims.
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities.
- Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity).
- Health information technology to support these activities.
- Enhancing the use of health care data to improve quality, transparency and outcomes, and support meaningful use of health information technology.

Exclusions

Expenditures and activities that **must not be included** in quality improving activities are:

- Those that are designed primarily to control or contain costs.
- The *pro rata* share of expenses that are for lines of business or products other than LA Medicaid.
- Those which otherwise meet the definitions for quality improvement activities, but which were paid for with grant money or other funding separate from DHH capitation payments.
- Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services.
- Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims [for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 USC 1320d-2, as amended, including the new ICD-10 requirements].
- That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.
- All retrospective and concurrent utilization review.
- Fraud prevention activities, other than fraud detection/recovery expenses up to the amount recovered that reduces incurred claims.
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason.
- Provider credentialing.
- Marketing expenses.
- Costs associated with calculating and administering individual enrollee or employee incentives.

- That portion of prospective utilization that does not meet the definition of activities that improve health quality.
- State and federal taxes and regulatory fees.
- Any function or activity not expressly included in paragraph (c) of this section, unless otherwise approved by and within the discretion of DHH, upon adequate showing by the BAYOU Health Contractor that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting health care quality improvement.

Other administrative expenses – The following expenses as designated as other administrative expenses:

Specification	Inclusion	Exclusion
Utilization management and concurrent review	Utilization management activities that manage medically-necessary covered services, as well as prospective and concurrent utilization review.	
Network development and credentialing costs	Contracting, provider credentialing and provider education.	
Marketing	Sales and marketing expenditures.	
Member services	Member service/support and grievance and appeals, including recipient enrollment.	
General and operational management	General and Operational Management – Senior operational management and general administrative support [e.g., administrative assistants, public relations (to the extent that it does not relate to marketing or member/enrollment services as described below), receptionist, etc.].	
Accounting and finance	Accounting and finance expenditures.	
Claims and referral/authorization processing	Processing of Provider Payments – Expenditures related to the processing and authorizing of provider payments.	
Information systems	Information systems and communications.	
Administrative services only (ASO) cost	Vendor-related expenditures for the processing of provider payments.	
Other direct costs	Administrative Business Expenditures – Rent, utilities, office supplies, printing and copier expenses, marketing materials, training and education, recruiting, relocation, travel, depreciation and amortization, and other miscellaneous administrative expenses. Payments to incent providers to submit encounter forms.	

Specification	Inclusion	Exclusion
Indirect costs – corporate overhead allocations	Corporate Overhead Allocations – Management fees, and other allocations of corporate expenses based on some methodology [e.g., per member per month (PMPM), percent of revenue, percent of head counts and/or full time equivalents (FTE), etc.].	
Sanctions and late payment interest penalties	Sanctions and other penalties paid or accrued by the Contractor.	
Other administrative costs	Those administrative expenses not specifically identified in the categories above. Note: Material amounts (greater than 5% of total administrative expenses) should be disclosed and fully explained in Schedule B.	Other administrative expenses indicated above.

Additional non-operating items are required to be reported within Schedule A. These items are described below:

Non-operating income/loss	Any amounts relating to the non-operating revenues and expenses.
Income taxes	Income tax expense paid or accrued for the period.
Premium tax assessments	Premium taxes paid or accrued for the period.
HIPF paid for 2013	IRS assessed HIPF paid in 2014.
HIPF accrued for 2014	Accrued HIPF payable in 2015 for 2014 premiums. Pursuant to FASB 2011-06, this amount should be $0 and amounts should not be expensed until the year assessed and paid.
Other	Any other income/loss not included elsewhere in the income statement. Note: Amounts should be disclosed and fully explained in Schedule B.

Allocation of expenses

General Requirements

Each expense must be reported under only one type of expense unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses. Expenditures that benefit lines of business other than LA Medicaid must be reported on a pro rata share.

- Allocation to each category should be based on a generally-accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above generally will be the most accurate method. If a specific identification is not feasible, the Contractor must provide an explanation of why it believes the more accurate result will be gained from allocation of

expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses.

- Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense.
- Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, capitation payment ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

2.02 Schedule B: Footnote Disclosures

The financial statement footnotes are designed to present information regarding organizational structures and changes to reimbursement methodologies, as well as an area to explain other amounts not specified in the reporting package. The following list is not exclusive of explanations that may be useful to DHH. Appendix A includes required annual financial disclosures. On a quarterly basis, only include narrative and applicable supporting schedules for material changes to items described in the following table:

	Footnote disclosure requirements	**Indicate as N/A if no reportable items**
1	Organizational structure	
2	Summary of significant accounting policies changes	
3	Other amounts included in the financial statements > 5% of the reporting category	
4	Pledges, assignments and guarantees	
5	Statutory deposits or performance bond changes	
6	Material adjustments to financial statements	
7	Changes to liability estimation methodologies or margin assumptions	
8	Claims payable RBUCs analysis	
9	Contingent liabilities	
10	Due from/to affiliates (current and non-current)	
11	Related party transaction activities	
12	Equity contributions or distributions/other activity	
13	Non-compliance with financial viability standards and performance guidelines	
14	Charitable contributions, penalties or sanctions included in the financial statements	
15	Interest on late claims	
16	Changes in provider reimbursement methodologies	
17	Changes to reinsurance or stop loss agreements	
18	Non-operating income/loss amount observations	
19	Other recovery amounts	

20	Claims payment fluctuations reported in the Lag reports, schedules O–S	
21	Unpaid claim adjustment expenses and methodology	
22	Premium deficiency reserves and methodology	
23	Allocation methodologies used for profitability statements	
24	Administrative expense allocation methodology changes	
25	Non-covered services and amounts paid	
26	Differences between premium assessment tax payments and capitated tax provision	

2.03 Schedules C – L: Total Profitability by Eligibility Category

These reports are meant to provide detailed information on revenues and expenses pertaining to the Contractor for the current quarter for the populations selected by DHH. Schedule C is automatically calculated from the county-based profitability reports (income statements). Schedules D through L report the results by region and should be reported based on the member's place of residence. The table below lists the population groups and associated data elements that help define each group for reporting purposes.

Population category	Aid Category	Rate Code
SSI 0–2 Months M/F	01	01C
SSI 3–11 Months M/F	01	02C
SSI 1–5 M/F	01	03C
SSI 6–13 M/F	01	04C
SSI 14–18 M/F	01	05C
SSI 19–44 M/F	01	06C
SSI 45+ M/F	01	07C
Family and Children 0–2 Months M/F	02	01C
Family and Children 3–11 Months M/F	02	02C
Family and Children 1–5 M/F	02	03C
Family and Children 6–13 M/F	02	04C
Family and Children 14–18 Female	02	05F
Family and Children 14–18 Male	02	05M
Family and Children 19–44 Female	02	06F
Family and Children 19–44 Male	02	06M
Family and Children 45+ Female	02	07F
Family and Children 45+ Male	02	07M
Foster Care Children All Ages	03	FLL
Breast and Cervical Cancer, F All ages	04	BLL
LaCHIP Affordable Plan	05	LLL
HCBS 18 and under	06	H01
HCBS 19 and over	06	H02

Region	Region Code
New Orleans	01
Baton Rouge	02
Thibodaux	03
Lafayette	04
Lake Charles	05
Alexandria	06
Shreveport	07
Monroe	08
Mandeville	09

2.04 Schedule M: Medical Liability Summary

This schedule combines summary information from the following schedules:

- Received but unpaid claims report
- Hospital Inpatient Lag report
- Outpatient Facility Lag schedule
- Physician Services Lag schedule
- Other Medical Lag schedule
- Pharmaceutical Lag schedule

The amounts to include in the rows and columns are self-explanatory, with a description at the bottom of the table on the following page of how the table is calculated. Prepare this schedule for both quarterly and YTD amounts.

Medical cost grouping	Paid claims	RBUC	IBNR	Current period ending IBNP	Current period beginning IBNP	Total recognized incurred claims
Hospitalization	$ -	$ -	$ -	$ -	$ -	$ -
Outpatient facility	$ -	$ -	$ -	$ -	$ -	$ -
Physician services	$ -	$ -	$ -	$ -	$ -	$ -
Other medical	$ -	$ -	$ -	$ -	$ -	$ -
Pharmaceutical	$ -	$ -	$ -	$ -	$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -	$ -
Notes and explanations:	A	B	C	D	E	F
	These amounts are produced by the lag schedules.	These amounts are produced by the RBUC schedule.	These amounts are calculated by the Contractor (C = D – B)	These amounts are produced by the lag schedules.	These amounts are produced by the prior quarter lag schedules.	F = (A + D) – E

The Medical Liability Summary report IBNR claims should be reported in the IBNR column by the appropriate category (e.g., hospitalization, outpatient, physician, other medical and pharmaceutical). The total payable for hospitalization, outpatient, physician, other medical and pharmaceutical should agree with the totals on the corresponding lag schedules.

2.05 Schedule N: Received But Unpaid Claims (RBUCs) Report

RBUCs are to be reported by the appropriate expense (for example, hospitalization, outpatient, physician, other medical and pharmaceutical) and aging (for example, 1–30 days, 31–60 days, 61–90 days, 91–120 days and greater than 120 days). Note that a claim becomes an RBUC the day it is received by the Contractor, not the day it is processed/adjudicated. For RBUC estimates, Contractors are encouraged to run reports close to the reporting deadline to determine a more accurate estimate of adjudicated and paid amounts for claims that were in

process as of the reporting period. Claims that are still in process and not yet adjudicated require an estimation technique by the Contractor based on average payment amounts or historical payment-to-billed ratios. Any late payment interest penalty payments should be listed next to the vendor for which payments were made.

2.06 Schedules O – S: Lag reports

Schedules O through S request the same type of information, but for different consolidated services categories (hospitalization, outpatient, physician, other medical and pharmaceutical). The tables are arranged with the month of service horizontally and the month of payment vertically. Therefore, payments made during the current month for services rendered during the current month would be reported in line 1, column C, while payments made during the current month for services rendered in prior months would be reported on line 1, columns D through AM. Lines 1 through 3 contain data for payments made in the current quarter. Earlier data on lines 4 through 37 shall match data on appropriate lines on the prior period's submission. If lines 4 through 37 change from the prior period's submission, include an explanation. The current month is the last month of the period that is being reported.

Analyzing the accuracy of historical medical claims liability estimates is helpful in assessing the adequacy of current liabilities. This schedule provides the necessary information to make this analysis.

Medical costs must be reported net of third party liability (TPL) and coordination of benefits (COB). Claims liabilities should **not** include the administrative portion of claim settlement expenses. Any liability for future claim settlement expense **must be disclosed separately** from the unpaid claim liability in a footnote.

Note: Multiple-month inpatient stays should be recorded in the admission month.

Line 39 – Global/subcapitation payments and pharmacy rebates: The Contractor should report global subcapitation payments on this line, by month of payment, which should not be included in any lines above line 39. Global/Subcapitation payments include:

- Global Capitation payments: Payments made to fully-delegated risk entities contracted with the Contractor. These types of payments are expected to be broken out between the hospitalization, outpatient facility, physician services and other medical service lag reports.
- Subcapitation payments: Those services paid through a normal provider capitation agreement. Examples would include PMPM payments to a primary care physician for a specified list of services or to a laboratory for a specified list of tests.

In addition, for the pharmacy lag schedule, the Contractor should report pharmacy rebates received as a negative number on this line. This will result in a reduction to pharmaceutical expenses.

Line 40 – **Settlements**: The Contractor should report payments/recoupments on lines 1 through 37 to the extent possible. If the Contractor makes a settlement or other payment that cannot be reported on lines 1 through 37 due to lack of data, the amount must be reported on line 40 with the payment month used as a substitute for the service month. The Contractor may use an alternative method of reporting settlements that restates prior period amounts to reflect an actual settlement for that month. **For all amounts reported on line 40, include a footnote explanation**. Do not include adjustments to IBNR amounts on this line.

Settlements should include payments to or refunds from providers that cannot be linked to a specific claim adjudicated through the payment system. For instance, fraud and abuse recoupment, incentive payments and inaccurate payment settlement agreements with a provider that have not been captured through the claims payment system should be included.

Line 41 – This line is the total amount paid to date (including subcapitation) for services rendered and should equal the sum of lines 38 through 40. This line will calculate automatically.

Line 42 – **Incurred but not reported (IBNR):** Amounts on this line represent the current estimates for unpaid claims, by month of service, for the past 36 months and the aggregate amount for all prior months. The Contractor must determine a new IBNR amount for each service month and include this amount on line 42. The development of each IBNR should be based on the most recent paid claims data.

Line 43 – **Total incurred claims:** Total incurred claims is the sum of line 41 (amounts paid to date) and line 42 (IBNR). These amounts represent current estimated amounts ultimately to be paid for medical services by month of service for the past 36 months and for all months prior to the 36th month. Each amount represents the medical expense for a particular month, not including adjustments to prior month IBNR claims estimates. This amount is comprised of claims for the incurred month that are known to be paid by the end of the reporting quarter, plus claims for the incurred month estimated to be unpaid at the end of the reporting quarter. Also included are subcapitations and adjustments.

Do not include risk pool distributions as payments in these schedules.

Schedules O through S must provide data for the period beginning with the first month the Contractor is responsible for providing medical benefits to DHH recipients, and ending with the current month.

2.07 Schedule T: Utilization report

The Contractor shall submit a summary of utilization and unit cost information during the current quarter. Data must reconcile to the consolidated financial submissions. Input areas are highlighted in red where data should be entered, including the quarterly member months.

Admissions, days, visits and quantities should be reported on an incurred basis for the quarter being reported upon, as counted from authorizations or claims adjudication data. Estimates for claims still not received as of the report due date should be estimated so that the utilization is representative of the actual occurrence of services performed for the reporting period.

Service measure	Measure	Type of utilization/ proxy	Definitions
Hospitalization	Days	Quantity/days	Days are calculated as follows: Number of days between admit and discharge date. (Exclude discharge date and denied days. Include admit day.) If dates are equal, inpatient day is counted as one. Days counted should be all paid days of service for each admission that occurred in the period. If the admission and discharge do not occur in the same period, all days are counted as occurring in the period in which the admission occurs. Include data for which the Contractor is both the primary payer and the secondary payer.
Outpatient services	Visits	Quantity/services	This measure summarizes utilization of outpatient services and observation room stays that result in discharge. Each visit to an emergency department that does not result in an admission should be counted once, regardless of the intensity of care required during the stay or the length of stay. Patients admitted to the hospital from the emergency department should not be included in counts of visits. Visits to urgent care centers should be counted. Include data for which the Contractor is both the primary payer and the secondary payer.
Physician services	Visits	Quantity/services	A visit is defined as one or more professional contacts between a patient and a unique service provider on a unique date of service. Include data for which the Contractor is both the primary payer and the secondary payer.
Other medical services	Visits	Quantity/services	A visit or service is defined as one or more professional contacts between a patient and a unique service provider on a unique date of service. For nursing facility stays, count the days as consistent with the hospitalization service measure. Include data for which the Contractor is both the primary payer and the secondary payer.

2.08 Schedule U: Pharmaceutical Statistics

This report provides data on key measures of price and utilization for pharmaceutical services. Portions of the data are provided by recipient group. The Contractor will submit one report in each quarterly submission for the most recent service quarter.

With the exception of specialty drugs, data presented in this report shall include only outpatient prescription volume adjudicated through the contracted claims processor (for example, contracted PBM) or in-house claims processor.

- A prescription is defined as one fill of a prescription that is obtained from a pharmacy based on a written order to supply a particular medication for a specific patient with instruction for its use. For specialty drugs, include all pharmacy and medical claims for both prescriptions dispensed by outpatient pharmacies and medical claims for specialty drugs administered and billed through physician offices, with the exception of reporting the discounts (lines 12 and 13), in which only the prescriptions dispensed through outpatient pharmacies should be included. Specialty medications associated with an inpatient prescription are not to be included in this report.
- For select measures, each category shall also be sorted and reported as a brand, or a generic claim based on the status of the product on the date of service/adjudication.
- Specialty drugs are defined as all prescriptions dispensed from outpatient pharmacies and physician offices.
- Brand/generic definition: The recommended methodology to classify brand/ generic status is based upon a combination of generic indicators provided by First Data Bank (FDB); the Innovator (INNOV), the New Drug Application (NDA), the Generic Therapeutic Indicator (GTI), and the Generic Manufacturer Indicator (GMI).
  - A Brand is defined by the following hierarchy of indicators:
    (1) NDC with an Innovator (INNOV) value of “1”
    (2) NDC with a New Drug Application (NDA) value of “1”
    (3) NDC with a Generic Therapeutic indicator (GTI) of “2”
    (4) NDC with a Generic Therapeutic indicator (GIT) of “4” and a Generic Manufacturer Indicator (GMI) of “2”
  - All other values and combination of values defined a generic drug
- Brand and generic dispensing fee should be reported as the actual average paid per claim and not the contracted dispensing fee. The average dispensing fee = (total dispensing fee paid) / (total number of claims).
- The per claim administration fee should include only those fees paid to the Contractor’s pharmacy vendor for administration of the pharmacy benefit. Internal Contractor costs associated with administration of the pharmacy benefit should not be included.

CATEGORY	MEASURE	DEFINITIONS
1	Brand dispensing fee	Average fee paid to pharmacies to dispense any brand name drug (e.g. legend, OTC and non-drug) for both single-source and multi-source products. Brand dispensing fee should be reported as the actual average paid per claim and not the contracted dispensing fee (excluding specialty, usual and customary (U&C) and TPL claims).
2	Generic dispensing fee	Average fee paid to pharmacies to dispense any generic drug (e.g. legend, over the counter (OTC) and non-drug). Generic dispensing fee should be reported as the actual average paid

CATEGORY	MEASURE	DEFINITIONS
		per claim and not the contracted and dispensing fee (excluding specialty, U&C and TPL claims).
3	Specialty brand dispensing fee	Average fee paid to pharmacies to dispense any brand name specialty drug for both single-source and multi-source products. Brand dispensing fee should be reported as the actual average paid per claim and not the contracted specialty dispensing fee.
4	Specialty generic dispensing fee	Average fee paid to pharmacies to dispense any generic specialty drug. Generic dispensing fee should be reported as the actual average paid per claim and not the contracted specialty dispensing fee.
5	Average rebate per claim (non-specialty)	Average dollar amount of rebates expected to be received for prescriptions (excluding specialty drug claims) filled in the reporting period divided by total number of prescriptions (excluding specialty drug claims) filled in the reporting period – brand and generic. This estimate should be reported on an accrual basis, net of any rebate splits, and should include any expected amounts that are not guaranteed.
6	Average specialty rebate per specialty claim	Average dollar amount of specialty rebates expected to be received for specialty prescriptions filled in the reporting period divided by total number of specialty prescriptions filled in the reporting period – brand and generic. This estimate should be reported on an accrual basis, net of any rebate splits, and should include any expected amounts that are not guaranteed.
7	Administrative fee per claim	Administrative fee (usually paid by the Contractor to a contracted PBM or claim administrator) on a per claim basis for pharmacy claim adjudication and management. Do not include internal Contractor costs associated with the administration of the pharmacy benefit.
8	Generic dispensing rate (GDR)	Divide the total number of generic prescription by the total number of prescription dispensed in a given period.
9	Multi-source brand utilization	Brand drugs that, at the time of dispensing, were available from a brand name manufacturer and also from a generic manufacturer. (e.g. Zocor dispensed when generic Simvastatin was available)
10	Average discount for brand prescriptions (non-specialty)	Defined as 1 – (discounted amount paid for all brand name drugs (e.g., legend, OTC and non-drug) dispensed (excluding specialty, U&C and TPL claims) / 100% amount of brand name drugs dispensed).
11	Average discount for generic prescriptions (non-specialty)	Defined as 1 – (discounted amount paid for all generic drugs (e.g., legend, OTC and non-drug) dispensed (excluding specialty, U&C and TPL claims) / 100% amount of generic name drugs dispensed).
12	Average discount for specialty brand prescriptions	Defined as 1 – (discounted amount paid for all specialty brand name drugs dispensed (excluding U&C, TPL, and specialty claims dispensed through the physician's office) / 100% amount of specialty brand name drugs dispensed).
13	Average discount for specialty generic prescriptions	Defined as 1 – (discounted amount paid for all specialty generic drugs dispensed (excluding U&C, TPL, and specialty

CATEGORY	MEASURE	DEFINITIONS
		claims dispensed through the physician's office) / 100% amount of specialty generic drugs dispensed).
14	Specialty Utilizers as a % of members	Defined as number of members on specialty drugs for the quarter over the total member months for the quarter for each rate cell.
15	Total number of 340b pharmacy claims	Defined as total number of 340b pharmacy prescription claims (including specialty drug claims) reimbursed by the Contractor during the reporting period.
16	Total reimbursed amount for 340b claims	Defined as total dollar amount reimbursed by the Contractor to pharmacies for 340 pharmacy prescription claims (including specialty drug claims) during the reporting period.
17	% retail prescriptions	Defined as percentage of retail prescription claims reimbursed by the Contractor over the total prescription claims.
18	% mail prescriptions	Defined as percentage of mail prescription claims reimbursed by the Contractor over the total prescription claims.
19	Total brand number of prescription claims	Defined as total number of brand prescription claims reimbursed by the Contractor during the reporting period
20	Total generic number of prescription claims	Defined as total number of generic prescription claims reimbursed by the Contractor during the reporting period
21	Total specialty number of prescription claims	Defined as total number of specialty prescription claims reimbursed by the Contractor during the reporting period.
22	Overall total number of prescription claims	Defined as overall total number of claims reimbursed by the Contractor to pharmacies for total prescription claims (including brand, generic and specialty drug claims) during the reporting period.
23	Total brand reimbursed amount	Defined as total dollar amount reimbursed by the Contractor to pharmacies for brand prescription claims during the reporting period.
24	Total generic reimbursed amount	Defined as total dollar amount reimbursed by the Contractor to pharmacies for generic prescription claims during the reporting period.
25	Total specialty reimbursed amount	Defined as total dollar amount reimbursed by the Contractor to pharmacies for specialty prescription claims during the reporting period.
26	Overall total reimbursed amount	Defined as overall total dollar amount reimbursed by the Contractor to pharmacies for prescription claims (including brand, generic and specialty drug claims) during the reporting period.

2.09 Schedule V: Sub-Capitated Expense report

This report is a summary of sub-capitation expenses, by population group, by individual expense line item. If other capitation agreements exist and are listed in the miscellaneous medical expense line item, please describe the capitation agreement in the financial statement footnotes.

2.10 Schedule W: FQHC and Rural Health Clinic Payments

This report is a summary of Contractor payments to FQHCs and RHCs for services, and a comparison of those payments to each FQHC's or RHC's Prospective Payment System (PPS) rates. The Contractor is to reimburse FQHCs/RHCs the PPS rates in effect on the dates of service for all encounters (Section 9.2.3 of the RFP).

As PPS rates may vary by provider and change periodically, the schedule is designed to capture information by provider by quarter. List quarterly aggregate payments and encounters by provider, as well as the PPS rates in effect for the effective dates of service. In order for the reported payments to reconcile with other schedules, this schedule is designed for reporting based upon dates of service. Amounts reported should be based upon the Contractor's anticipated (accrued) payments for services even if actual payments have not yet been paid.

However, as PPS rates may change within a reporting period, reporting payments by quarter allows for direct comparison to such rates. Although only one entry per provider will typically be necessary within any given quarter, if payments change within a quarter (for example, scope of service change, etc.), report the aggregate amounts on different lines for the same quarter corresponding to the different PPS rates for their effective periods. For example, if a PPS rate changed on 9/1/12 for FQHC A, report the aggregate payments and encounters for 7/1/12–8/31/12 on one line, and the aggregate payments and encounters for 9/1/12–9/30/12 on another. Both lines can be referenced with the same quarterly identification, and a clarifying disclosure should be provided in Schedule AF.

Quarterly references should coincide with the Contractor's fiscal year, with Q1 being the first quarter of the fiscal period, followed by Q2-Q4 respectively. Quarter months should always correspond to January–March, April–June, July–September, and October–December.

Encounters for FQHC/RHC providers are based upon the DHH definition of encounters for FQHC/RHC services, and is correlated to PPS rate determination. Report the number of encounters corresponding to the payments listed. Generally, in spite of the number of medical services provided on any given day (that is, line detail), an enrollee receives one encounter per day.

The Contractor is responsible for reporting PPS rates in effect for the dates services were provided. PPS rates may be obtained from the provider or DHH, but should be the rates issued by DHH.

The Contractor's payments per encounter are automatically calculated within the report (Accrued Amounts divided by Encounters), as are the Equivalent PPS Payments (Encounters multiplied by the PPS Rates). Any variance between the Contractor's payments and the calculated PPS equivalents is also automatically calculated. Describe the reason for any variance, by provider, on Schedule AF. Negative variances indicate the contractually required PPS rates have not been paid, and a complete explanation is required on Schedule AF.

2.11 Schedule X: Third Party Resource Payments

This schedule provides detail regarding total claims payments and claims paid that had other coverage.

- Count of total claims paid: report all claims paid by the Contractor during the reporting quarter. The count of total claims paid will only be entered within the “Commercial” section of the template. The “Medicare” and “Total” claims will populate automatically. **NOTE:** The count of total claims paid should be ALL claims paid by the Contractor and NOT only those claims that had commercial or Medicare as primary payor.
- Count of claims paid with other insurance indicated: report all claims paid by the Contractor during the reporting period where the member had other insurance coverage. This should include claims paid at $0.00 due to other insurance payments greater than Contractor allowed amounts. In addition, claims should be reported even if the other insurance paid $0.00 for the claim due to services not covered by other insurance. Please see below for examples. The count of claims reported here is a subset of the “count of total claims paid”.
- Contractor allowed amount: report the Contractor allowed amount associated with the claims reported in “count of claims paid with other insurance indicated”.
- Contractor paid amount: report the total Contractor paid amount associated with the claims reported in “count of claims paid with other insurance indicated”.
- Other insurance paid amount: report the total amount paid by other insurers associated with the claims reported in “count of claims paid with other insurance indicated”.

Two examples are discussed below and illustrate how to report the information:

- The Contractor receives and pays a claim and the member has Medicare coverage. The Contractor allowed amount for the service is $65 and Medicare paid $80. The Contractor paid amount for this should be $0 since Medicare paid more than the Contractor allowed amount. For this report, the Contractor would report $65 as Contractor allowed amount, $0 as Contractor paid amount and $65 as other insurance paid amount. Note: the other insurance paid amount should not be greater than the Contractor allowed amount. This claim would be counted in both the “count of total claims paid” and the “count of claims paid with other insurance indicated”.
- The Contractor receives and pays a claim and the member has other coverage. The Contractor allowed amount for this service is $50. However, the other insurance does not cover the Medicaid allowed service so other insurance pays $0. For this report, the Contractor would report $50 as Contractor allowed amount, $50 as Contractor paid amount and $0 as other insurance paid amount. This claim would be counted in both the “count of total claims paid” and the “count of claims paid with other insurance indicated”.

Report the count of members with active third-party liability (TPL) resources at the end of the quarter on lines 14 and 15. Report an unduplicated count of members with active TPL resources at the end of the quarter on line 16 (that is, a member could be included in both lines 14 and 15 but should only be reported once in line 16).

2.12 Schedule Y: Third Party Liability Subrogation Claims

List all new, active and closed subrogation cases for the quarter. Include the count of related subrogation claims for each case by the attorney name and/or case ID number. Indicate with a “Y” if the case is new, active or closed. Report any amount recorded as a public record lien for each case.

2.13 Schedule Z: Fraud and Abuse Activity

List all new, active and closed fraud and abuse cases for the quarter. Include the count of related claims for each case by the provider name and/or case ID number. Indicate with a “Y” if

the case is new, active or closed. Do not include member-specific names or identification numbers on the schedule.

2.14 Schedule AE: Medical Loss Rebate (MLR) calculation

This schedule should be completed for the quarterly MLR calculation. Please note that the quarterly MLR calculation will be used for informational purposes only by DHH. The quarterly schedule will not be utilized for determination of payments from the Contractor to DHH. The information reported should be on a year-to-date basis. Therefore, the quarterly report for June 30, 20XX will include financial data from January 1, 20XX through June 30, 20XX and would be due on August 29, 20XX (60 days after quarter end).

2.15 Schedule AF: Supplemental working area

This schedule should be used by Contractors for working purposes or as a supplemental reference area for quarterly financial statement footnote disclosures.

2.16 Schedule AG: Maternity and Deliveries

This schedule combines summary information from maternity and delivery revenue and expenses, identified as either early elective deliveries or non-early elective deliveries. Early elective deliveries are either induced or performed without medical necessity. Medical expenses to be included on this schedule should be classified consistent with the major category of service groupings on Schedule A – Income Statement. Expenses should be included for the following:

- Facility Bill Codes: 650.xx – 669.xx or V27.xx (xx represents any fourth and/or fifth digit of the diagnosis code that may appear).
- Professional Bill Codes: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, or 59622.

3

Annual audit reporting requirements

3.01 Schedule AA: Parent company audited financial statements

Insert the final audited parent company financial statements within this tab within 120 days after year end. Preferably, this can be accomplished by embedding the final statements in PDF format.

3.02 Schedule AB: Contractor agreed upon procedures

The agreed upon procedures are in effect for the annual reporting period ending each December 31st, and shall be submitted by June 30th of the subsequent year. Preferably, this can be accomplished by embedding the final audited financial statements in PDF format.

3.03 Schedule AC: Income statement reconciliation report

Any changes from the fourth quarter YTD quarterly submission schedules based upon the agreed upon procedures should be reconciled within this report.

3.04 Schedule AD: Agreed upon procedures adjustment entries

This schedule should list annual agreed upon procedures adjustment entries, if applicable, with an explanation of each entry. Materiality threshold: Any adjustment that exceeds $5,000, or all adjustments, if, in aggregate, they exceed .25% of capitation revenue must be reported as a line item. Adjustments that are $5000 or less may be excluded if, in aggregate, the sum total of all adjustments is less than .25% of capitation revenue from line 3 of Schedule A.

3.05 Schedule AE: Medical Loss Rebate (MLR) calculation

This schedule provides the calculations necessary at year end to determine any rebates payable to DHH based on adjusted adjustments to revenue and expenses as defined in Appendix B of this Financial Reporting Guide. The schedule should only be completed after the agreed upon procedures have been finalized.

3.06 Schedule AF: Supplemental working area

This schedule should be used by Contractors for working purposes or as a supplemental reference area for annual financial statement footnote disclosures.

Appendix A

Annual financial statement disclosures and supplemental information requests

Appendix A is a separate word document of financial disclosure requirements and information requests that must be reported by the Contractor at year end. The schedule is in three sections and includes financial disclosures, related party transactions and supplemental information requests. The supplemental information requests may be inserted in either Appendix A, the supplemental working area on Schedule AF or a clearly labeled separate attachment.

Appendix B

Medical Loss Ratio (MLR) Rebate Calculation

Appendix B includes the instructions and guidance for calculating any rebate amounts due to DHH. The document is adapted from 45 CFR Part 158 Federal Register, December 1, 2010. Requirements for calculating any rebate amounts that may be due the DHH in the event the BAYOU Health Contractor does not meet the 85% MLR standard are described in this appendix.

Medical Loss Ratio (MLR) Requirements

Coordinated Care Networks (CCNs) that receive capitation payments to provide core benefits and services to Louisiana Medicaid members are required to rebate a portion of the capitation payment to DHH in the event the CCN does not meet the eighty five percentage (85%) MLR standard. This document describes requirements for 1) reporting MLR, 2) methodology for calculation of MLR, 3) record retention 4) payment of any rebate due DHH, and 4) monetary penalties that may be assessed against the CNN for failure to meet requirements.

Definitions

Direct Paid Claims – claim payments before ceded reinsurance and excluding assumed reinsurance except as otherwise provided in this Appendix.

MLR Reporting Year – calendar year during which core benefits and services are provided to Louisiana Medicaid members through contract with DHH.

Unpaid Claim Reserves – reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within three months of the end of the MLR reporting year.

Reporting Requirements

A. **General Requirements**
For each MLR reporting year, the CCN must submit to DHH a report which complies with the requirements that follow concerning capitation payments received and expenses related to Louisiana Medicaid enrollees (referred to hereafter as MLR Report).

B. **Timing and Form of Report**
The annual report for each MLR reporting year must be submitted to DHH by June 1 following the end of an MLR reporting year, using the form and in the manner prescribed by DHH. A link to the form can be found here: http://new.dhh.louisiana.gov/index.cfm/page/278.

C. **Newer Experience**

If 50 percent or more of the total capitation payment received in an MLR reporting year is attributable to new Medicaid enrollees with less than 12 months of experience with the reporting entity in that MLR reporting year, then the experience of these enrollees may be excluded from the MLR Report. If the CCN chooses to defer reporting of newer business, then the excluded experience must be added to the experience reported in the following MLR reporting year.

For Medical Loss Ratio rebate calculation purposes, new enrollees assigned to a prepaid plan within a calendar year are identified as those that have not been continuously enrolled with the plan. Continuous enrollment is defined, for this purpose, as being enrolled for a minimum of 11 months in a calendar year, including enrollment months prior to the current calendar year. Enrollment spans must be separated by 63 days or more to qualify as separate enrollment spans; intervening months shall be included in the monthly count in determining the total months of continuous eligibility if comprised of 62 days or less. HEDIS rules for continuous enrollment do not apply for MLR rebate calculation purposes.

Continuous enrollment shall be determined on plan enrollment, and shall not consider changes in category of eligibility, region or age/gender classification as changes to enrollment spans.

To quantify the impact of New Enrollees:

1. List all plan enrollees during the MLR period (total population)
2. Using continuous membership spans from initial enrollment (including months prior to the MLR period), identify members from the population that have NOT had continuous enrollment for a minimum of 11 months (this subgroup represents the potential New Enrollees).
3. Review the potential New Enrollees, identifying those members that had initial enrollment (no enrollment prior to MLR period), and those with intermittent membership spans. Review the intermittent membership spans to determine if any breaks in membership were for periods of 62 days or less; if so, combine the spans and include the months between spans to determine if they meet the 11 months continuous enrollment threshold. The potential New Enrollees should now be able to be separated between defined New Enrollees (those with less than 11 months of continuous enrollment including intermittent membership spans) and the non-New Enrollees (those with 11 months or more continuous enrollment including intermittent membership spans).
4. Determine the total capitation for the total population and the total capitation for the defined New Enrollees. If the defined New Enrollee Capitation is greater than 50% of the Total Population Capitation, the defined New Enrollees capitation and expenses may be deferred to the next MLR period. If the percentage is less than 50%, all of the membership should be included in the current MRL period.
5. Review the prior MLR period to determine if the defined New Enrollees revenue and expenses from the prior MLR period was deferred to the current period. If it was deferred, include the capitation and expense from the prior period *defined* New Enrollees in the current period.

D. **Capitation Payments**

A CCN must report to DHH the total capitation payments received from Louisiana Medicaid for each MLR reporting year. Total capitation payments means all monies paid by DHH to the CCN for providing core benefits and services as defined in the terms of the contract.

Reimbursement for Clinical Services Provided to Enrollees

A. **General Requirements**

The MLR Report must include direct claims paid to or received by providers, whose services are covered by the subcontract for clinical services or supplies covered by DHH's contract with the CCN. In addition, the report must include claim reserves associated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the claim portion of lawsuits, and any experience rating refunds paid or received. Reimbursement for clinical services as defined in this section is referred to as "incurred claims."

1. Incurred Claims must include changes in unpaid claims between the prior year's and the current year's unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to subcontracted providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.

2. Incurred claims must include the change in claims incurred but not reported from the prior year to the current year. Except where inapplicable, the reserve should be based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.

3. Incurred claims must include changes in other claims-related reserves.

4. Incurred claims must exclude rebates paid to DHH based upon prior MLR reporting year experience.

B. **Adjustments to incurred claims:**

1. Adjustments that must be deducted from incurred claims:

    a. Prescription drug rebates received by the CCN
    b. Overpayment recoveries received from providers

2. Adjustments that may be **included** in incurred claims:

    a. The amount of incentive and bonus payments made to providers

3. Adjustments that must not be included in incurred claims:

    a. Amounts paid to third party vendors for secondary network savings
    b. Amounts paid to third party vendors for network development administrative fees, claims processing, and utilization management
    c. Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee. For example, medical record copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks must not be included in incurred claims.

Activities that Improve Health Care Quality

A. **General Requirements**
The MLR may include expenditures for activities that improve health care quality, as described in this section.

B. **Activity Requirements**
Activities conducted by a CCN to improve quality must meet the following requirements:

1. The activity must be primarily designed to:

   a. Improve health quality;
   b. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;
   c. Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees;
   d. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations;
   e. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations:

      1. Examples include the direct interaction of the CCN (including those services delegated by subcontract for which the CCN retains ultimate responsibility under the terms of the contract with DHH) with providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:

         (a) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in the RFP and contract;
         (b) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
         (c) Quality reporting and documentation of care in non-electronic format;
         (d) Health information technology to support these activities;

   f. Accreditation fees directly related to quality of care activities;

   g. Prevent hospital readmissions through a comprehensive program for hospital discharge;

      1. Examples include:

(a) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
(b) Patient-centered education and counseling;
(c) Personalized post-discharge reinforcement and counseling by an appropriate health care professional;
(d) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and,
(e) Health information technology to support these activities.

h. Improve patient safety, reduce medical errors, and lower infection and mortality rates.

1. Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

(a) The appropriate identification and use of best clinical practices to avoid harm;
(b) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;
(c) Activities to lower the risk of facility-acquired infections;
(d) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions;
(e) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and,
(f) Health information technology to support these activities.

i. Implement, promote, and increase wellness and health activities:

1. Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include:

(a) Wellness assessments;
(b) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
(c) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
(d) Public health education campaigns that are performed in conjunction with the Louisiana Office of Public Health ;
(e) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in payments or claims;
(f) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(g) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and,
(h) Health information technology to support these activities.
(i) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology.

A. **Exclusions**

1. Expenditures and activities that **must not be included** in quality improving activities are:

    a. Those that are designed primarily to control or contain costs;
    b. The *pro rata* share of expenses that are for lines of business or products other than Louisiana Medicaid;
    c. Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from DHH capitation payments;
    d. Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
    e. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements);
    f. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
    g. All retrospective and concurrent utilization review;
    h. Fraud prevention activities, other than fraud detection/recovery expenses up to the amount recovered that reduces incurred claims;
    i. The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
    j. Provider credentialing;
    k. Marketing expenses;
    l. Costs associated with calculating and administering individual enrollee or employee incentives;
    m. That portion of prospective utilization that does not meet the definition of activities that improve health quality;
    n. State and federal taxes. licensing and regulatory fees; and,
    o. Any function or activity not expressly included in paragraph (c) of this section, unless otherwise approved by and within the discretion of DHH, upon adequate showing by the CCN that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting health care quality improvement.

Expenditures Related to Health Information Technology and Meaningful Use Requirements

A. **General Requirements**

A CCN may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities that are designed for use by the CCN, CCN providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with HHS meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

1. Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services;
2. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicaid incentive payments;
3. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
4. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA, URAC, or JHACO, or costs for reporting to DHH on quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures);
5. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.;
6. Advancing the ability of enrollees, providers, CCNs or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management;
7. Reformatting, transmitting or reporting data to national or international government-based health organizations, as may be required by DHH, for the purposes of identifying or treating specific conditions or controlling the spread of disease; and,
8. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

Other Non-Claims Costs

A. **General Requirements**

The MLR Report must include non-claims costs described in paragraph B of this section and must provide an explanation of how capitation payments are used, other than to provide reimbursement for clinical services included in core benefits and services, expenditures for activities that improve health care quality, and expenditures related to Health Information Technology and meaningful use requirements.

B. **Non-Claims Costs Other**

1. The MLR Report must include any expenses for administrative services that do not constitute adjustments to capitation for clinical services to enrollees, or expenditures on quality improvement activities as defined above.

2. Expenses for administrative services include the following:

    a. Cost-containment expenses not included as an expenditure related to a qualifying quality activity;
    b. Loss adjustment expenses not classified as a cost containment expense;
    c. Workforce salaries and benefits;
    d. General and administrative expenses; and,
    e. Community benefits expenditures.

Allocation of Expenses

A. **General Requirements**

Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit lines of business other than Louisiana Medicaid must be reported on a pro rata share.

B. **Description of the Methods Used to Allocate Expenses**

The report required must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, and other non-claims costs resulting from CCN activities in Louisiana. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

1. Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the CCN must provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses;
2. Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned *pro rata* to the entities incurring the expense; and,
3. Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, capitation payment ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group. Any profit margin included in costs for related party administrative agreements should be excluded.

C. **Maintenance of Records**
The CCN must maintain and make available to DHH upon request the data used to allocate expenses reported, together with all supporting information required to determine that the methods identified and reported as required under paragraph (b) of this section were accurately implemented in preparing the MLR Report.

Formula for Calculating Medical Loss Ratio

A. **Medical Loss Ratio**

1. A CCN's MLR is the ratio of the numerator, as defined in paragraph “a” of this section, to the denominator, as defined in paragraph “b” of this section.

2. A CCN's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

    a. The **numerator** of a CCN's MLR for an MLR reporting year must be the CCN's incurred claims plus the CCN's expenditures for activities that improve health care quality. The numerator of an MLR reporting year shall include Total Medical Expenses defined as follows:
        a. Incurred claims
        b. Plus MLR Expense Addition Adjustments as applicable:
            i. State subsidized stop loss payments.
            ii. Provider incentive or bonus payments.
            iii. Administrative expense activities that improve health care quality.
            iv. Health Information Technology meaningful use expenses.
            v. Add the New Enrollee expenses deferred from the prior MLR reporting year as defined on page 28 of this guide.
            vi. Other adjustments for non-claim costs.
        c. Minus MLR Expense Reduction Adjustments as applicable:
            i. Claims that are recoverable for anticipated COB.
            ii. Subrogation recoveries.
            iii. Amounts paid to third party vendors for secondary network savings.
            iv. Amounts paid to providers for non-covered services.
            v. Prior year rebates paid to DHH.
            vi. Pharmacy rebates.
            vii. Provider overpayments recovered.
            viii. Administrative expense exclusions.

    b. The **denominator** of a CCN's MLR must equal the CCN's capitation payments received from DHH. The denominator of an MLR reporting year shall include Total Capitation Revenue less premium taxes unless a deduction for community benefit expenditures is taken, less the Health Insurance Provider Fee (HIPF). Premium taxes and HIPF are excluded because they are all considered pass-through administrative costs and including reimbursement for them would adversely affect ratios. The following adjustments may apply:

a. Subtract the New Enrollee capitation and expense impact for the current MLR reporting year as defined on page 28 of this guide
b. Add the New Enrollee capitation deferred from the prior MLR reporting year as defined on page 28 of this guide.

Rebating Capitation Payments if the 85% Medical Loss Ratio Standard is Not Met

A. **General Requirement**
For each MLR reporting year, a CCN must provide a rebate to DHH if the CCN's MLR does not meet or exceed the eight five percentage (85%) requirement.

B. **Amount of Rebate**
For each MLR reporting year, a CCN must rebate to DHH the difference between the total amount of capitation payments received by the CCN from DHH multiplied by the required MLR of 85% and the CCN's actual MLR.

C. **Timing of Rebate**
A CCN must provide any rebate owing to DHH no later than August 1 following the end of the MLR reporting year.

D. **Late Payment Interest**
A CCN that fails to pay any rebate owing to DHH in accordance with paragraph "B" of this section or to take other required action within the time periods set forth in this Part must, in addition to providing the required rebate to DHH, pay DHH interest at the current Federal Reserve Board lending rate or ten percent annually, whichever is higher, on the total amount of the rebate, accruing from August 1.